Revised FY2014-2015

KY Child and Adult Care Food Program Income Application
2014-2015 Adult Day Care Centers

This form must have ALL SECTIONS COMPLETE in order for this center to qualify for reimbursement for meals served to the participants.

1. **PARTICIPANT INFORMATION** (print) 2. **PROGRAM BENEFITS** (Full Program Number Must Be Listed)

Name of Participant	Birthdate	SNAP#	SSI #	Medicaid #
1.				
2.				
3.				
4.				
5.				

3. **HOUSEHOLD MEMBERS AND MONTHLY INCOME**:

NAMES OF HOUSEHOLD MEMBERS LAST	FIRST	GROSS MONTHLY Income From Work (Before Deductions)	MONTHLY Income From Welfare Payments, Alimony	MONTHLY Income From Pensions Retirement Social Security	Any Other MONTHLY Income
1.		$	$	$	$
2.		$	$	$	$
3.		$	$	$	$
4.		$	$	$	$

4. SIGNATURE AND SOCIAL SECURITY NUMBER: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

X_____ X_____ X_____
Signature of Adult Household Member | Date | Last 4 digits of Social Security Number*

Home Telephone No. _____Work Telephone No. _____Printed Name _____

Street/Apt.No._____City/State/Zip_____

5. Participant's ethnic and racial identities (optional). Mark one ethnic identity: _____ Hispanic or Latino _____ Not Hispanic or Latino

Mark one or more racial identities: _____ Asian _____ White _____ Black or African American _____ American Indian or Alaska Native _____ Native Hawaiian or Other Pacific Islander

*See Policy Memo

FOR SPONSOR USE ONLY. DO NOT WRITE BELOW THIS LINE.

_____ SNAP/SSI/Medicaid Household

_____ Income Household

Total Household Monthly Income: _____

Household Size: _____

Application approved for:
- ☐ Free Meals
- ☐ Reduced Price Meals
- ☐ Paid

_____ _____ _____ _____
Signature of Determining Official | Date | W/D Date | Re-enter Date